

Trauma Registry Web Portal



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Course Description

The WI Web Portal is a tool that enables users to access the central site trauma registry to enter data and access reports. This course will provide instruction for users on how to enter data into the registry as well as how to select and prepare reports for their hospitals.



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Course Objectives

- Access the Web Portal
- Enter data into the Trauma Registry via the Web Portal
- Use Tri-Code™ for injury coding
- Access and run reports from the Web Portal



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Session Format

- Three-Part Lecture with Software Demonstration
 - Web Portal Access & Log In
 - Trauma Registry
 - Report Runner
- Handouts
- Practice Exercises



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Web Portal



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Web Portal Address

<https://wi.traumaregistry.com/>



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Web Portal Log-in

- Enter a User Name
- Enter a Password
- Enter a Facility
- Select <Login> button



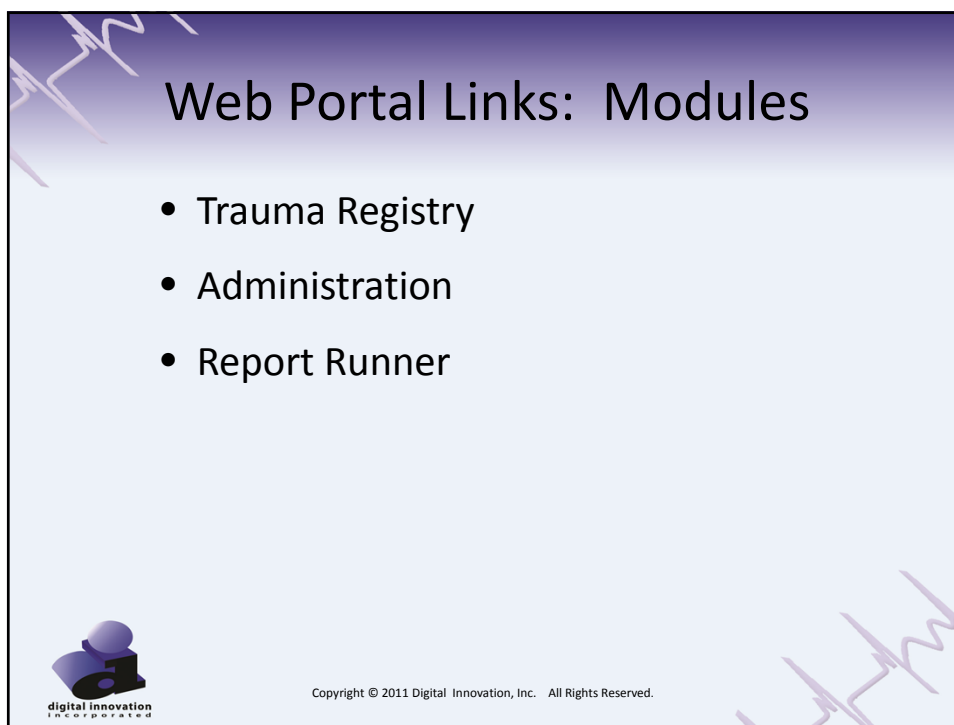
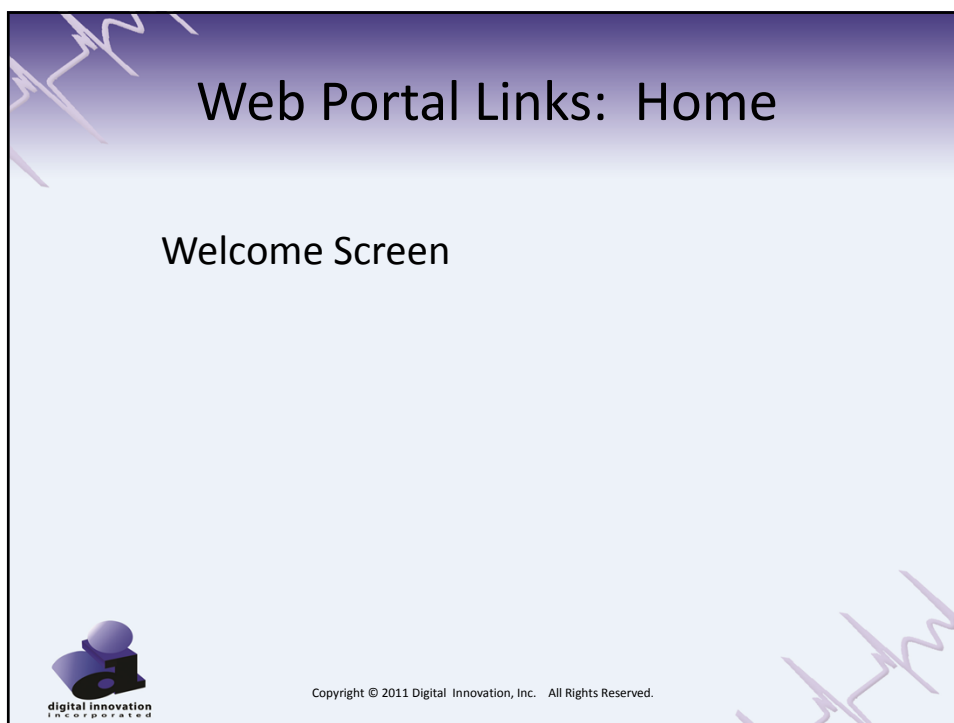
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Web Portal Welcome Screen

- Links
 - Home
 - Modules
 - Upload Reports
 - Review Reports
 - Support
- Change Password
- Logout



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Web Portal Links: Upload Reports

Used *by the State* to post reports for

- Individual Hospitals to pick up
- Regions to pick up
- Everyone to pick up



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Web Portal Links: Review Reports

- Location of stored reports
- Based on Permissions
 - User ID
 - Facility ID
- Posted by
 - State from Upload Reports Link
 - Individual User from within Report Runner History Screen



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Web Portal Links: Support

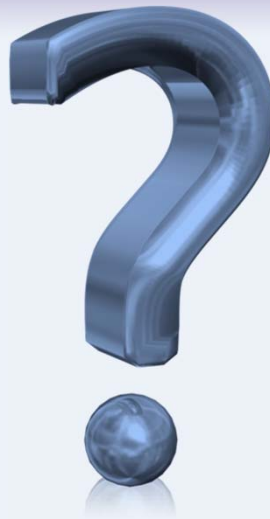
Methods to gain assistance with questions or issues regarding use of the software.

- Email
- Web site
- Phone / TTY call via Skype



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Software Demonstration



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Trauma Registry



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Trauma Registry Overview

- The Trauma Registry Module manages data entry.
- The Trauma Registry is used for the following tasks:
 - Adding trauma records
 - Searching for trauma records
 - Editing trauma records
 - Viewing trauma records
 - Deleting trauma records



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Trauma Registry Access

- Select <Modules>
- Select <Trauma Registry>



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Record Manager: Purpose

- Displays a selected subset of the trauma records included in the Trauma Registry.
- The subset of records is filtered based on:
 - the hospital Facility ID entered on the login screen
 - the search criteria entered by the user



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Record Manager: Content

- Rows of patient information
- Columns
- Function buttons



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Record Manager: Columns

- Trauma #
- Facility Name
- Last Name
- First Name
- Arrival Date
- Discharge Date
- Record Status



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Record Manager: Sorting Columns

- Can sort only **one** column at a time.
- Using the mouse, left-click on the column to be sorted.



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Record Manager: Relocating Columns

- Can move column location.
- Drag & Drop the Column to the desired location.
- Location change is only preserved for the current session.



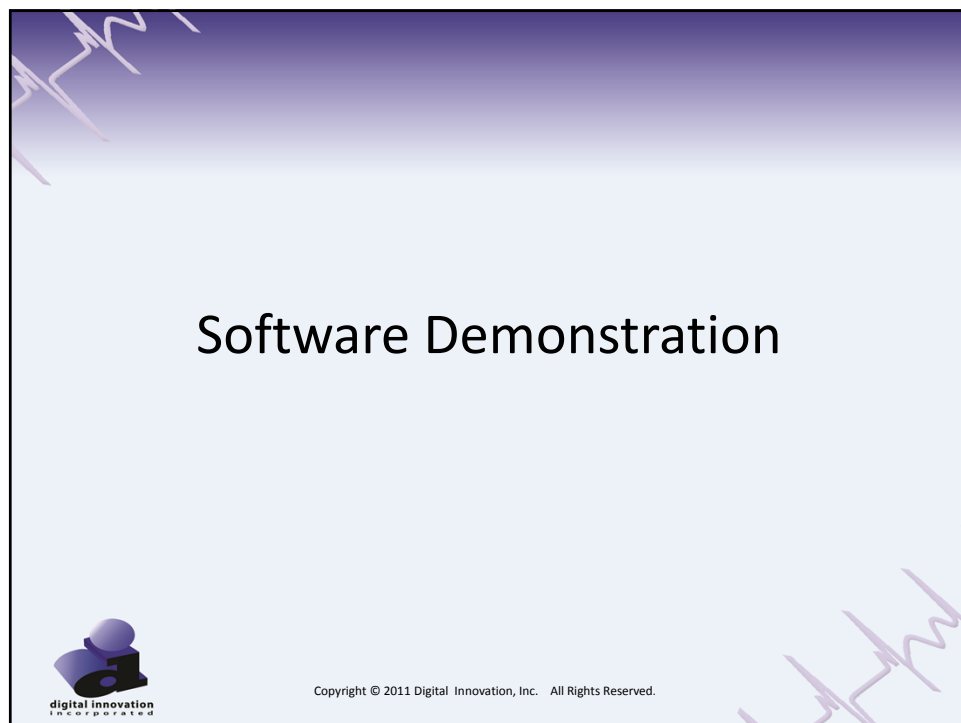
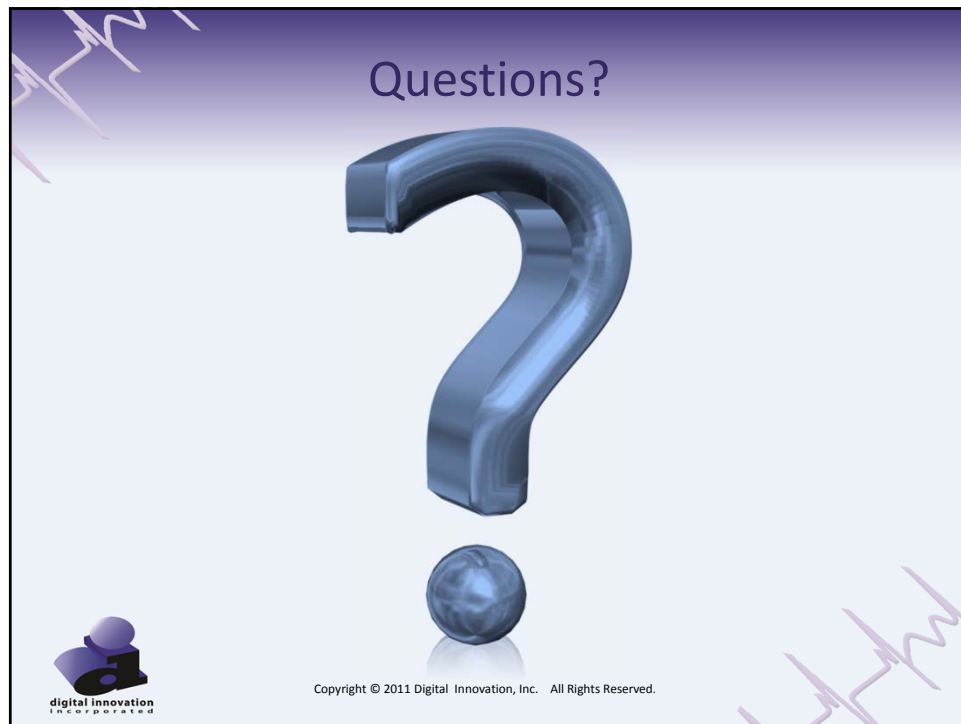
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Record Manager: Function Buttons

- Refresh
- Search
- Add
- Edit
- View
- Delete
- Export



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Navigating Within a Trauma Record

- Screen
 - Navigation Buttons
 - Previous
 - Next
 - Screen Tabs
- Field
 - Enter data
 - Tab
 - Click



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Trauma Record Screens

- Demographics
- Injury Data
- First Responder
- First EMS Provider
- Secondary Transport from Scene
- Referring Facility
- ED / Admission
- Outcome
- Injury Diagnosis



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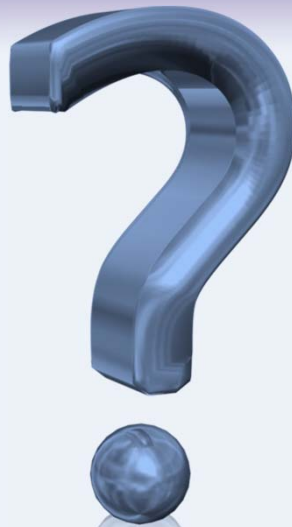
Data Element Types

- Auto-populated
- Free Text
- Drop Down Menus
- Pop Up Code Menus
- Date Fields
- Time Fields
- Memo Fields
- Detail Grids
- Yes / No Boxes



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Coding Diagnoses

- Tri-Code
- Manual



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Tri-Code: Overview

- Based on Abbreviate Injury Scale (AIS)
- Dependent on injury description



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Tri-Code: Why?

- Ranked as an expert ICD-9 and AIS coder.
- Allows for fast, accurate coding of injuries.
- Converts simple textual injury descriptions to ICD-9, AIS, and ISS scores.
- Provides uniform coding for trending and outcome studies.
- Allows for accurate comparisons of data across different datasets.
- Provides a statistical way to accurately measure the severity of a patient's injuries.



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Tri-Code: Rules

- Enter one injury description per line
- Enter a complete injury description
 - Anatomic structure
 - Type of injury
 - Extent of injury
 - Location (side of injury Left, Right)
- Common abbreviations may be used
- Enter **all** of a patient's injuries
- Enter only definitive diagnoses



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Tri-Code: Action Taken

- Processes and codes each injury description
- Upgrades severities due to the presence of other injuries, when appropriate
- Identifies the ICD-9-CM code, the AIS PREDOT code, and the severity score for each injury as well as those associated with upgrades



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Tri-Code: Injury Narrative

- Enter injury descriptions into the Injury Narrative Field
- Specific guidelines can be found in the Tri-Code User Manual (Abstracting Injury Descriptions)



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Tri-Code: Execution

- Select the Tri-Code button
- The Anatomical Diagnoses information will auto-populate



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Tri-Code: Overwriting Previous Codes

- Change injury narrative to reflect necessary changes
- Select the Tri-Code Button
- When the <Confirm Tri-Code> message appears, select the OK Button



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Manual Coding

- In the Anatomical Diagnosis section, select the Add button
- Enter the desired ICD-9 Code
- Enter the desired Predot
- Select the AIS Severity
- Select the ISS Body Region
- Select the OK Button



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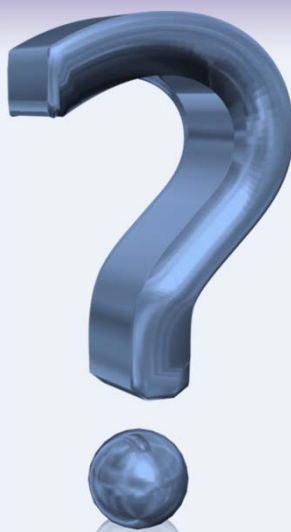
Trauma Record: Save Options

- Located at the bottom of the trauma record window
- Select Save to save the current trauma record
- Select Save/Exit to save the current trauma record and exit
- Select Cancel to exit the record without saving changes
 - The Confirm Cancel screen will open. Select OK to confirm the cancel without saving.
 - Select Cancel to remain in the current trauma record



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Validation Checks

- Purpose
- Types of checks:
 - Blank / Required
 - Sequence
 - Range
 - Duplicate



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Checks: Executing

- Can be executed at any time from within the trauma record
- Best practice is to execute after data abstraction has been completed
- Select the Check button on the bottom left of the patient record



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Checks: Correcting Data

- Click on the field containing the error triggering data
- Enter correct data



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Checks: Validating / Overriding

- If the data is correct, click on the Validate button
- Use Caution! Inappropriate validation can lead to unreliable data



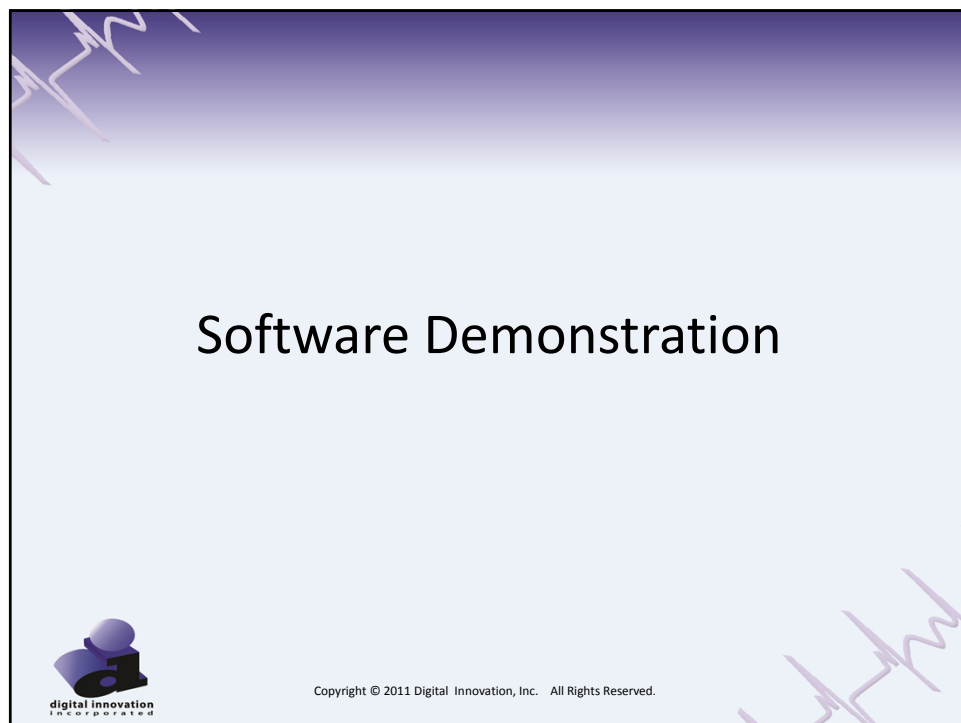
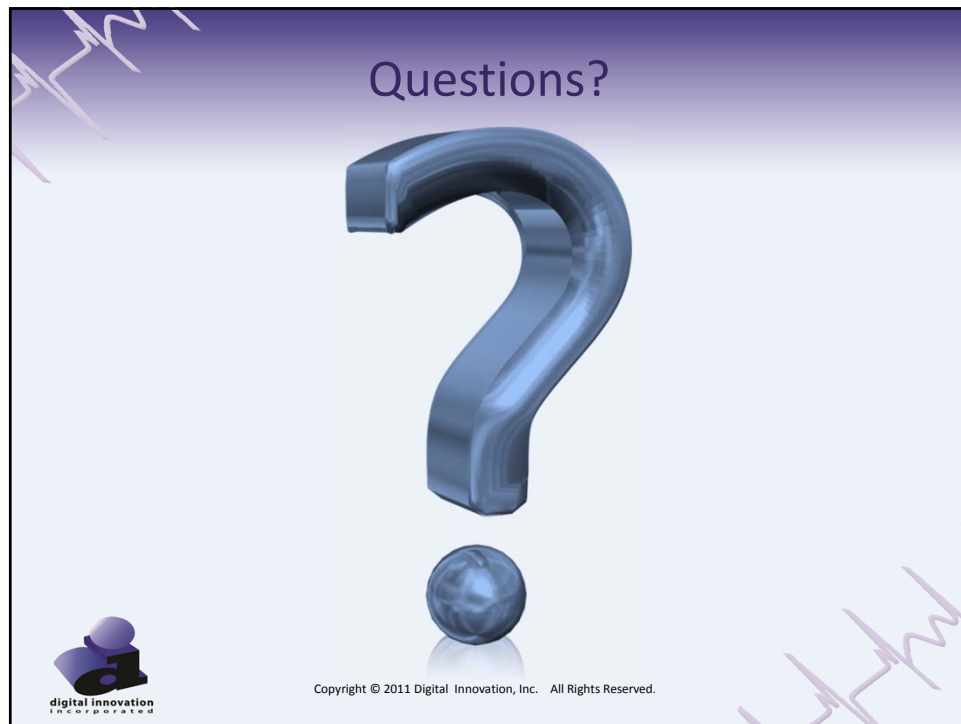
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Closed Record Status

- Indicates that checks have been performed and validated on the current record
- Once all check issues are resolved, the Checks Resolved screen will open. Select OK
- Select Save or Save/Exit to save the validated record
- The record status will now update from Active to Closed



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Report Runner



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Report Runner: Purpose

Provides the user with pre-built objects to review / analyze data contained within the trauma registry.



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Report Runner: Access

From the Web Portal Welcome Screen

- Click on the <Modules> link
- Click on the <Report Runner> link



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Report Runner: Tabs

- Report
- History



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Report Tab: Selection

- Report
 - Answers the question WHAT?
 - What do I want to see
- Query
 - Answers the question WHO?
 - Creates a subset of the patient population
- Gather
 - Answers the question HOW?
 - How do I want to group values for comparison



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Data Completeness Reports

- Demographic
- Injury
- Prehospital – First Responder
- Prehospital – Primary EMS Provider
- Prehospital – Primary EMS Provider GCS
- Prehospital – Secondary Transport
- Referring Facility
- ED / Admission
- Outcome



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Other Reports

- Demographics
- Data Form Facsimile
- Mini Trauma Service Summary
- Patient Record List
- PRE Charts (AIS 85, 9x)
- PRE Charts (AIS 2005)
- Patient Record List
- z and W



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Queries

- Ages
 - Pediatrics (≤ 14)
 - Adults (15 – 64)
 - Geriatrics (≥ 65)
- Discharge Status
 - Alive
 - Dead
- Gender
 - Male
 - Female



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Gathers

- Age
- ED Arrival by Day of Week
- ED Disposition
- Gender
- Injury Type
- ISS
- Race



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Report Tab: Function Buttons

- Run
- Clear Report Selection
- Clear Report Options



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Report Tab: Report Options

- Facility ID
- Trauma #
- Arrival Date Between
- Discharge Date Between



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History Tab: Manager

- ID
- Submitted
- Report
- Gather
- Query
- Status
- Status Message



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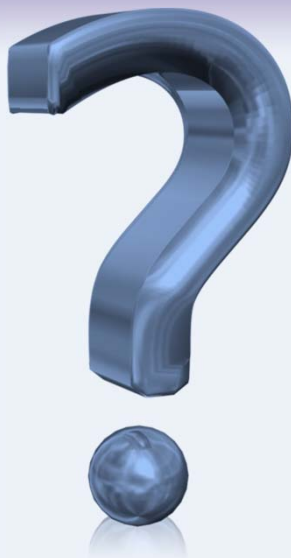
History Tab: Function Buttons

- View
- Post
- Rerun
- Delete



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Mix and Match



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Mix and Match: Philosophy

Each report can be run by itself or with any query and/or gather, increasing the flexibility and strength of the report writer.



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Example: Patient Record List

When run by itself, the Patient Record List:

1. Provides a list of **all patients in the registry** (for the records specified).



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Example: Patient Record List

When run with a query for non-survivors, it:

1. Provides a listing of trauma registry numbers for only those **patients who did not survive**.



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Example: Patient Record List

When run with a gather by age it:

1. Provides a listing of trauma registry numbers for **all patients in the registry**
2. Groups them by age ranges.



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Example: Patient Record List

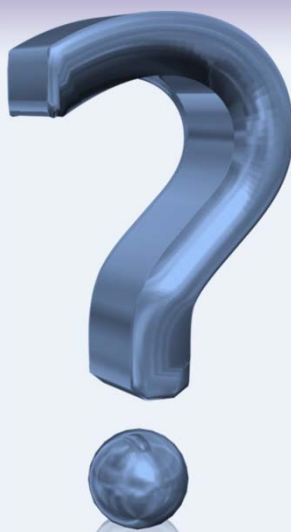
When run with a query for survivors and a gather by age:

1. Provides a listing of trauma registry numbers for only those **patients** in the registry **who survived**
2. Groups them by age ranges.



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